DOCUMENT RESUME

ED 407 765 EC 305 483

AUTHOR Slomka, Gregory T.
TITLE Functional Assessment.
INSTITUTION Pittsburgh Univ., Pa. Dept. of Rehabilitation Science and Technology.
SPONS AGENCY Rehabilitation Services Administration (ED), Washington, DC.
PUB DATE 96
NOTE 55p.; Section 10.4 of "Clinical Internship Training Program in Psychiatric Vocational Rehabilitation"; see EC 305 482.
PUB TYPE Information Analyses (070) -- Tests/Questionnaires (160)
EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Behavior Rating Scales; Check Lists; Definitions; *Evaluation Methods; *Mental Disorders; *Performance Based Assessment; Psychiatry; Resource Allocation; Skill Development; *Vocational Evaluation; *Vocational Rehabilitation
IDENTIFIERS *Functional Assessment; Psychiatric Rehabilitation

ABSTRACT

This report provides an overview of the use of functional assessment in the evaluation of individuals with psychiatric disabilities. It begins by discussing the difficulties with traditional forms of assessment and the development of functional assessment, particularly in the field of psychiatric rehabilitation. The need to not rely on any single modality for assessment, but to incorporate functional assessment methodologies into a larger framework of comprehensive evaluation is emphasized. Topics covered in the report include: (1) the definition and uses of functional assessment; (2) the methodologies of functional assessment (including behavioral interviewing techniques, direct observation techniques, self-observation techniques, and checklists, questionnaires, and rating scales); (3) general principles of functional assessment; (4) special functional impairments in populations with chronic mental illness; (5) behavioral assessment strategies; (6) behavioral excesses, deficits, and assets; (7) the nested skills approach to assessment and training; and (8) resource management. A form is provided for evaluating the psychosocial profile of a subject along with a critical skills checklist. Appendices include a summary of the information for use in a slide presentation. (Contains 29 references.) (CR)

Functional Assessment

FUNCTIONAL ASSESSMENT

Gregory T. Slomka, Ph.D.

Traditional forms of assessment have generally been directed at native ability or capacity, ie., measures of inherent ability. This reflects a psychometric tradition in testing which was established in the 1950s. Measures of general ability such as intelligence and aptitude tests have been increasingly questioned in regard to their ability to predict outcomes with specific clinical populations. Over the years questions have been raised regarding the significance of scores on psychometric tests and their capacity to predict the ability of persons having disabilities to survive in the community.

It was perhaps within the traditions of services for persons diagnosed with mental retardation that this question was most poignantly raised. Traditional assessment with this population relied heavily upon evaluation of formal intelligence with little consideration of other factors. With mandates for least restrictive treatment alternatives and the development of community based treatment services came an awareness of glaring discrepancies in the ability of traditional assessment technologies to aid in treatment and service planning. An anti-psychometric movement, in conjunction with the burgeoning development of "behaviorism," arose within some quarters of the field of the developmental disabilities. Central in this regard was the criticism that traditional testing led only to the generation of generic labels, ie., "Moderate Mental Retardation." Assessment solely for diagnostic or classification purposes was viewed as counterproductive, since it showed little benefit in advancing the predictive potential of individual habilitation efforts.

Within this zeitgeist, we saw the emergence and subsequent development

of a radically different assessment technology, that of functional assessment. In only a few years over 125 functional assessment instruments were developed. These instruments purported to increase treatment planning efficacy by refocusing the assessment upon a pragmatic evaluation of individual strengths and weaknesses that a client might show in his or her adaption to specific environmental contexts. At this point, we tended to see dichotomous camps of those who held rigidly to "traditional assessment" and those who ignored this source of data only to focus on outcome measures of adaptive skill competency. In their landmark overview text Mental Deficiency (Clarke and and Clarke (1976)), offered an alternative approach toward evaluation. S.1 Table 1 summarizes their definition of "assessment" which unified aspects from both camps. Central to this model is the recognition of the need to combine

Table 1

An Integration of Traditional and Functional Assessment Approaches

---

Assessment ...

1) Describes an individual at a particular point in time in terms of intellectual, social, emotional, educational, and allied variables with reference to a normative or contrast population.

2) Predicts performance of an individual at a future point in time.

3) Provides a profile of assets and deficits in order to determine the starting point for further intervention.

4) Provides an objective means to monitor progress over time.

From: Clarke & Clarke, 1976.

assessment technologies so as to develop an appreciation of client need "in toto."

The field of psychiatric rehabilitation has also seen an evolution of a functionally based system of assessment. The literature has reflected that in

terms of outcome traditional psychodiagnostic assessment methodologies did not correlate with eventual vocational outcome, community adjustment, or with the elucidation of skills requisite for overall community adjustment. A high degree of individual variability can frequently be seen among individuals sharing the same diagnosis. Ratings of personal, social, and work adjustment have, however, correlated highly with eventual client outcome. These ratings also have helped to describe how individual differences affect outcome.

A goal of psychiatric rehabilitation is to assure that an individual with a psychiatric disability can perform those skills necessary to live, work, and learn in his or her community with the least amount of support. Persons with psychiatric disabilities must be able to perform certain functional skills in order to maintain themselves independently in the community or to become re-integrated into the community at large. This is accomplished through two mediums: 1) teaching clients the skills necessary to function as independently as possible, and 2) developing community and environmental resources necessary to support or strengthen functioning if clients fall short of independence. Functional assessment methodologies provide not only a basis for individual prescriptive treatment planning, but also offer a means of addressing various systems-related concerns, such as evaluating intervention effectiveness, monitoring outcomes, and planning for anticipated needs.

The remainder of the discussion will focus upon a further elaboration of functional assessment issues as they pertain to individuals with chronic mental illness. The need to rely not upon any single modality for assessment, but to incorporate functional assessment methodologies into a larger framework of comprehensive evaluation will be emphasized throughout this discussion.

THE DEFINITION AND USES OF FUNCTIONAL ASSESSMENT

Simply defined, functional assessment is the measurement of what a person can and cannot do. That is, the elucidation of behavioral strengths and weaknesses as they relate to particular goals. It is undertaken to aid in determining the impact of physical and mental impairments on behavior. Functional assessment offers a broad range of potentially useful information in the treatment of persons with chronic mental illness. A comprehensive functional assessment allows for

S.2

S.3

a) the specification of both abilities and limitations in terms of self-care and instrumental skill functions;

b) the identification of the presence or absence of social and interpersonal skill deficits and strengths;

c) the identification of remediation, training, or compensation techniques; and

d) the identification of educational, vocational, and community support needs.

Strategies utilized in the process of functional assessment vary considerably both in terms of methodology and content. These strategies include both formal and informal techniques. In terms of informal techniques, the presenting background history and psychological test results provide a rich source of antidoctal information which is pertinent to the formation of impressions about functional skill integrity. In particular, psycho-educational, medical, and psychological test reports that provide expanded discussion of pertinent observations about performance, as well as scores, can be quite helpful. Third party reports of functional abilities are an additional resource which may be acquired from family members, professional colleagues, or others

S.4

knowledgeable about the client's skills. These types of information can often serve as a springboard for the development of more formalized assessment techniques. Caution is raised, however, regarding the use of information acquired in this fashion because such information lacks objectivity.

THE METHODOLOGIES OF FUNCTIONAL ASSESSMENT

Within the context of "formal" functional assessment, rating scales or questionnaires are often considered in the forefront, as these are the most prevalent and readily available techniques. They represent, however, but one methodology available for use in functional assessment. Table 2 presents four distinct models which can be applied to the functional assessment process. S.5

Table 2

Methods of Functional Assessment

Behavioral Interviewing
Direct Observation
Self-Observation
Checklists, Questionnaires, and Rating Scales

Behavioral Interviewing Techniques. In this methodology, the patient is asked to provide a direct or personal description of assets, deficits, and possible excesses in terms of critical behaviors. Some interviewers utilize a structured interview schedule; that is, all clients assessed would be screened across the same set of questions. Other practitioners are far less structured and utilize behavioral interviewing techniques within the context of a more open-ended, problem-centered interview. There are even recommended

assessment methodologies, such as those associated with the Vineland Social Maturity Scale, in which a formal questionnaire (rating scale) provides the basis for an interview. The interviewer does not simply ask a respondent to rate behavior item by item, but rather seeks descriptions of client ability across varied settings, and then utilizes this information to later rate and quantify items on the behavioral questionnaire.

Many clinicians favor the behavioral interviewing methodology for a number of obvious reasons. It "personalizes" the assessment experience and increases the personal role of the client in treatment planning. Critical behavioral issues can be immediately explored in terms of a hierarchy "What"..."When"..."Where"...and "How" so as to obtain knowledge of contingencies and reinforcers that may maintain or preclude specific behaviors. Behavioral interviewing also lends itself to refocusing the client upon phenomenological issues, i.e., what he or she may be doing, thinking, and feeling in specific situations. This process facilitates opportunities for the client to gain insight into those factors which may be contributing to his or her current condition. Finally, in such a process the patient is in an excellent position to aid in hierarchically organizing the "strengths" and "needs" lists. The prioritization of intervention goals becomes a personalized experience for the client. For the clinician, factors which might interfere with such a process become immediately recognized and can become the object of further counseling intervention.

Direct Observation Techniques. One of the most potent means available for functional assessment is the direct observation methodology. Here the client is directly observed "in vivo" or in simulated experiences and his or her

behavior is critically evaluated. A good example of this can be seen in the work of the occupational therapist. In order to assess lunch making skills, the client can be taken to an equipped kitchen facility and directly observed across a number of variables which include planning, organization, technique, and outcome. Although direct observation represents both the most valid and reliable means of behavioral assessment, it is also the most costly in terms of manhours.

Typically, we would be more likely to rely on time-sample event recording when using this methodology. Within a particular setting, at specified time intervals, specifically objectified behaviors can be observed in terms of presence, absence, frequency, duration, or intensity. In this fashion, multiple staff members could assume some responsibility for observation and recording of relevant data, thus making the process less labor intensive. Handbooks of behavior therapy are usually repleat with examples of how direct observation and recording techniques can be implemented to evaluate behavior. It is often staff ingenuity that leads to novel approaches toward this type of assessment.

Self-Observation Techniques. A related, but frequently ignored methodology, borrows many of the time- or event-sampling techniques of observational strategies, but uses the client to monitor the identified behavior. At specified time intervals, for example, the client stops, makes a behavioral "check," and enters data. These techniques are particularly valuable for cumulatively monitoring behavior over protracted time periods. Personal attention to appearance and hygiene represent a category of behavior well suited to this technique. In addition, log books, diaries, and event counters (frequency tallies) might be utilized. Central in this methodology is the

opportunity for the client actively to self-monitor behavior. In many persons with chronic mental illness, the deficit in the ability to self-monitor represents a primary impediment toward gaining greater social and community acceptance. The greater assimilation on the part of the client of critical self-appraisal of performance rather than reliance on third party evaluations offers an important barometer of autonomy and potential for success in independent living.

Checklists, Questionnaires, Rating Scales. Functional assessment inventories offer a number of distinct advantages in terms of feasibility, breadth of coverage, and economy of application. A number of instruments have been developed and applied across diverse treatment settings. They vary considerably in terms of length and breadth of coverage. In this paradigm, various behaviors are evaluated for presence-absence, quality, frequency, etc. They exist in a number of forms. Ratings may be provided by third parties familiar with the client, such as staff or family. Equivalent forms exist where the client rates his or her own behavior as well. There are instruments which focus exclusively around limited aspects of adaptive functioning, such as vocational skill competencies or self-care skills, while others provide more global ratings across a number of disparate behavioral categories. The attached Appendix provides reference to a diverse sampling of functional rating scales applicable across a number of patient groups. Despite the apparent diversity and availability of standardized rating scales, there remain a number of practical limitations associated with their use. Practitioners frequently report lack of sufficient specificity of the material sampled in comparison to the environmental contexts in which their clients function. An instrument

S.6
S.7
S.8

might under- or over-sample particular categories of behavior. Those which provide quantitative scores based on normative standardization frequently suffer from restrictive parameters associated with the reference population. A classic example of this is seen in the application of the prototypical functional inventory which is used with persons who are mentally retarded, the Adaptive Behavior Scale. The normative base for this instrument was clients who were institutionally served as opposed to clients who were served in community based programs. Although one of the most frequently cited assessment instruments in use with this population, it remains restricted in its normative application to only institutionally served clients.

Despite these limitations, the rating scale methodology serves a very valuable function in initial case management and service planning by providing a checklist for identification of the presence/absence of critical skills. In terms of aiding in monitoring treatment or service intervention, rating scales and checklists can serve as a base for pre- and post-intervention measures of performance and thus serve as outcome measures. The ideal instrument would offer not only an indication of the "presence or absence" of critical skills, but also the provision of scales which permit objective rating of the frequency of occurrence of targeted skills and the severity of behavioral deficits or maladaptive behaviors. As the development of inventories becomes more refined, we should see improvements particularly in this latter direction.

There remains yet another alternative for the practitioner of functional assessment, that of the development of unique, environmentally or programatically specific instrumentation. A sampling of standardized inventories can be taken in association with an inventory of critical behaviors important in a specific environmental context. Agency or program specific rating scales can

then be developed. Such measures can be utilized to develop targets for programatic intervention. It is also quite reasonable to attempt local normatization of such instruments, or to attempt development of criterion validation. An example of this might be that 80% of clients who scored above a specific rating scale score were also successful in transferring to a higher level of programming, it may become reasonable to develop as a treatment plan goal for other clients the attainment of a similar score as an indication of readiness for advancement. Here we see evidence of an instrument not only identifying targets for intervention, but also serving as a criterion measure in a treatment plan.

GENERAL PRINCIPLES OF FUNCTIONAL ASSESSMENT

Regardless of the methodology utilized for obtaining information regarding client assets and liabilities there are certain general principles which can be applied in conducting the assessment and extending this information into generalizations appropriate for treatment or service planning. Cohen and Anthony (1984) provide a number of practical recommendations in this regard. We have taken a number of these principles, which are shown in Table 3, and expanded upon them. Adherence to these principles helps to assure that functional assessment will be both meaningful and practical.

S.9

Table 3

The Principles of Functional Assessment

Functional assessment needs to relate to an overall rehabilitation goal that is environmentally specific.
The language of functional assessment must be behaviorally defined.
Functional assessment is always individualized.
Functional assessment must be comprehensive.
Functional assessment requires active client involvement.
Functional assessment should focus on strengths as well as deficits.
Functional assessment requires that the client and the evaluator understand both present and anticipated needs.

From: Cohen & Anthony, 1984.

Functional assessment must relate to an overall rehabilitation goal that is environmentally specific. The objective of assessment is to gain an understanding of the client's assets and liabilities as they relate to skill demands that are likely to be confronted within particular environments. The needs of the client may vary significantly across the settings in which he or she functions, i.e., the residential, the vocational work place, the eductional, or recreational. Assessment must, therefore, be "context specific". The evaluator cannot presume that a strength or deficit observed in one environment will necessarily translate across varied boundaries. A central problem we confront in dealing with persons with long term mental illness is the possibility that skills may not generalize across contexts. It is therefore important for the evaluator to consider actively the number of domains in which a particular behavior might have to be assessed. This principle further

S.10

S.11

reinforces the concept of "ecological validity" discussed earlier.

Environmental specificity is also significant because it is this feature which distinguishes functional assessment from more traditional forms of psychometric assessment. Traditional psychological assessment provides a general description of cognitive performance and personality. This description is gathered within the context of a unique social and environmental circumstance--the consulting room. Inferences are drawn and generalized to the broader environment based upon objective results and impressions. Traditional psychological assessment does not, however, provide an opportunity to assess either behavior as a function of the environment in which it occurs or to extend generalizations by specifying how behavior may differentiate across environments. Functional assessment, however, offers a means to assess behavior with "situational specifity." It thereby offers an excellent medium by which to expand upon the results of more traditional assessment methodologies. Utilization of both types of assessment is, therefore, highly recommended.

The language of functional assessment must be behaviorally defined. A "skill" S.12
represents a set of behaviors that are both observable and measurable, and S.13
therefore, "teachable." If we as evaluators are going to translate successfully S.14
observations of client performance into statements which program staff can S.15
act upon, we must convey this information in objective terms. If we are going to attempt to monitor client change, our observations must be in terms which are measurable. The "Rule of the five W's" is an aid in conceptualizing behavior in this fashion. Behaviors must be defined by WHO is performing it, WHAT behavior is the focus of the intervention, as well as by the circumstances associated with the behaviors -- the (WHERE, WHEN, and with

WHOM). These statements are advanced "positively" and in a language of "doing." Expectations for both the client and support personnel are clearly delineated in terms of issues of "personal responsibility."

Functional assessment is always individualized. Each client carries with him or her a unique and distinct phenomonology which sets him or her apart from every other individual. Too often the utilization of a stereotyped approach to behavioral assessment and treatment planning results in the re-application of "pat" formulations of problems and interventions. Too rigid an adherence to a mechanistic formulation of skill deficits that does not take into account "personal" variables can result in glaring failure. Clients are not "black boxes" that respond to stimulus-response heirarchies. S.16

Let us take an example of a not infrequent behavioral problem or symptom, enuresis. The sudden emergence of this problem in a client recently transferred to your program could signal any one of a number of possible underlying etiologies that would influence eventual treatment. So often in "behaviorally oriented" functional assessment there is a tendency to view outcome behavior to the exclusion of potential cause. In this case, the behavior manifested could have its basis in a functional etiology, i.e. anxiety related to transfer. From a psychodynamic perspective enuresis could represent regression to more primitive behavior in the face of weak ego defenses that have been challenged. From a behavioral perspective this same symptom could represent a manifestation of "learned helplessness" that was previously displayed when the client was confronted with uncertainty. A complex alternative set of hypothesis could be derived if we consider medical causes. Could uresis be a function of the sudden onset of diabetes, which is

often accompanied by increased urinary frequency? What about the possible neurological causes, such as normal pressure hydrocephalus? Finally, we must also consider yet another factor ever present when serving neuropsychiatric populations. The side effects of medication must be evaluated. This example sets the stage for the next principle of functional assessment.

Functional assessment must be comprehensive. It could be argued that this principle relates not only to the breadth and scope of the assessment methodology, per se, but also to the overall status of the client. That is his or her physical, emotional, social, and cognitive status. The above example highlights the fact that functional assessment does not occur in a vacuum. The active consideration of other assessment data accrued through multidisciplinary means is essential before embarking on treatment. S.17 S.18 S.19 S.20 S.21

This principle has other important implications. Assessment needs to occur across multiple environments. A comprehensive functional assessment also provides for the development of a data base. This data base allows for the construction of short term and intermediate range goals which are built sequentially into more global, long term goals. Such sequential planning is frequently facilitated by organizing the items in a functional assessment inventory into developmental sequences that reflect the normal order of the attainment of more complex behaviors.

Developing a comprehensive functional assessment means it is necessary to go beyond the assessment of pragmatic physical skills, i.e. meal preparation, grooming, handling public transportation. Behaviors must be cast in light of the emotional and intellectual status of the client because problems in these spheres can significantly negatively influence skill acquisition.

Functional assessment requires active client involvement. The extent to which the client is actively involved in the processes of both assessment and treatment planning enhances the probability that he or she will understand "what" will be required and "why". At first glance this may seem obvious. There is, however, a significant issue which relates to persons with long term mental illness and the problem of motivation. Indeed, special effort may have to be given to engaging the client in the assessment and planning process. Active incorporation of the client into treatment planning can aid in "empowerment". The better attuned the client becomes to what is required of him or her and, more importantly, to why it is required, the chances for successful rehabilitation increase. S.22

Functional assessment should focus on strengths as well as deficits. Our ultimate objective is to delineate what the client can as well as cannot do. Often, assessment personnel can slip into a tendency to overfocus on the identification of skill deficits. Functional deficits frequently noted in persons with chronic mental illness include the following: S.23 S.24

- impairment of abstract attitude
- concrete thinking
- inability to make generalizations
- misinterpretation of spoken, written language
- failure to attend
- lack of motivation
- failure to persist in tasks

- lack of eagerness at work
- inability to get along with others
- lack of initiative
- psychomotor abnormalities
- disturbance of memory and learning
- slow to process information
- difficulty in categorizing and organizing input

An important aspect of rehabilitation intervention, however, is the identification of areas of residual strength. Frequently it is upon these areas that the therapeutic intervention can be built in order to "remediate" or "compensate for" deficits. It is also important to note that persons with long term mental illness often readily develop a negative self-focus. Anticipation of failure can be a significant stumbling block. The identification of residual strengths can become an important source of therapeutic benefit for certain clients. The development of an improved self-image through this process then influences more positive motivation toward program goals.

Functional assessment requires that the client and the evaluator understand both present and anticipated needs. Rehabilitation effort is understood as a "process" that is ongoing. So, too, must evaluation be understood. The practitioner must assume the perspective, "Where is my client currently; where does he or she need to be in the immediate and long term future?" As indicated previously, it is critical that efforts be directed toward a superordinate goal. Assessment and intervention provide the bridges to span the gaps between the client's current status and intended outcomes. The process runs smoothly to the degree that both the client and practitioner

agree upon realistic goals and methods. Comprehensive functional assessment provides a valid basis for the decision making regarding intermediate goals which build logically toward more extended goals.

By considering the principles outlined above we can further refine our definition of functional assessment. According to Lawton (1971) functional assessment refers to "any systematic attempts to measure objectively the level at which a person is functioning in any of a variety of areas such as physical health, quality of self-maintenance, quality of role activity, intellectual status, social activity, attitude toward the world and toward self, and emotional status (p.). Conceived in this fashion, functional assessment as a methodology offers an approach to the central question confronted by service providers: How may I help my clients/patients who have chronic impairment to achieve maximum quality of life and independence in daily activities?"

At its simplest, functional assessment represents a means to describe S.26
abilities. Our goal as service and treatment providers is to develop a S.27
performance oriented data base or profile of our clients. From this profile S.28
problems and needs are mutually identified, interventions are planned, and long term goals are developed. Periodic re-evaluation across these performance measures provides the means to quantitatively ascertain progress toward the attainment of long term goals. In effect, functional assessment data provides S.29
a foundation of data relevant for many types of both case management as well as treatment related services.

If one adopts the recommendations described above for conducting any S.30
type of functional assessment, that is, behaviorally defining skills and needs S.31
in terms that are observable and measurable and following the "rule of the S.32

five W's", one has the groundwork available for the ready translation of raw data into prescriptive treatment plans.

We emphasize that functional assessment remains only one spoke in a more intricate wheel. Each client presents unique physical and biological endowments, cognitive strengths and weaknesses, affective characteristics, and interpersonal skills. The failure to assess instrumental community based adult daily living (ADL) skills or vocational skills against the backdrop of the aforementioned variables can lead to complications. We have attempted to convey the need to develop service planning only after comprehensive evaluations are complete. The most successful rehabilitation strategies are those which are built upon the client's existing skills, talents, and resources.

SPECIAL FUNCTIONAL IMPAIRMENTS IN POPULATIONS WITH CHRONIC MENTAL ILLNESS

The development of knowledge about how psychopathology is uniquely manifested across various syndromes is one function of the DSM-III-R classification system. We must, however, look beyond mere description and further examine how various symptom constellations impact daily functioning. The symptoms themselves can represent significant impediments to adaptive functioning. We will begin with a consideration of the psychoses and consider potential repercussions of such symptoms on performance. Delusions, hallucinations, and fantasies interfere with performance by blocking or diverting attention from reality demands. Autistic preoccupation significantly interferes with the ability to attend to or respond to interpersonal cues from the world at large. These symptoms are the most obvious, florid, and immediately disabling. They are, however, the symptoms which respond most

S.33

S.34

immediately to neuroleptic medications.

There are a number of more residual secondary symptoms which can be manifested even in the face of controlled Schneiderian First Rank Symptoms. Social isolation can reflect itself in anxiety or in severe interpersonal discomfort in social situations. Diminished attention to grooming and hygiene or the improper modulation of behavior in public may negatively influence social acceptance. Oddities in speech and mannerisms might further exacerbate this. Suspiciousness associated with paranoid ideation can radically affect factors such as response to constructive criticism. Subtle thought disorganization and impaired judgement and reasoning can negatively influence complex problem solving. The person who deals with the environment successfully possesses the ability to interpret social cues and react within the boundaries of normal social convention. It can be readily seen, therefore, that psychotic symptoms alone or in combination can seriously interfere with adaptive functioning.

We can also associate functional limitations with the symptoms accompanying the affective disorders. Depression, for example, conveys impressions of dysphoric mood and diminished performance ability. Clients vary significantly in the degree to which neurovegetative (sleep, appetite, and arousal state) symptoms are manifested. Fatigue and decreased energy can radically affect performance level on the job or in educational arenas. These symptoms may dissipate or they may remain chronically refractory in some patients, thus having long term repercussions. We are now also increasingly recognizing the "cognitive" as well as the affective repercussions of depressive disorders. Severe impairment in occupational efficiency, memory and concentration, and practical problem solving can occur and can be more

functionally debilitating in the workplace than the mood disturbance.

We have only briefly highlighted the "functional" ramifications of symptoms in order to emphasize the need to assess their impact upon a client's "everyday functioning." It is indeed relevant to take the individual symptomolgy associated with any DSM-III-R major psychiatric disorder and attempt to conceive its impact upon the client in the domains as seen in Table 4. The breakdown of symptom related problems into such subsets is one means of further understanding their specific impact and then individualizing potential intervention or compensatory strategies.

Table 4 S.35

Sub-sets of Symptom-Related Problems

Sensory-perceptual disturbance
Cognitive disturbance
Language related disturbances
Praxic (motor) disturbance
Disrupted executive functions

There is further advantage to maintaining a symptom-related focus while conducting functional assessment. Once symptoms and problems are clearly defined with this population, it is important to identify the factors which maintain them. Here we are emphasizing the need to understand the etiological underpinnings of problematic behavior from a biopsychosocial perspective. Treatment efforts should follow as a function of the identification of casual determinants. Psychological factors related to genetic, metabolic, and physical abnormalities may require primarily pharmacological

models of intervention. To the degree that psychosocial factors may influence the course of a disorder (onset, exacerbation, relapse and chronicity,) behavioral and social interventions will be more appropriate. In this case the clinician would focus more specifically on the antecedent and consequent events that maintain problematic behavior. Frequently, it is a combination of both treatment strategies that is required.

BEHAVIORAL ASSESSMENT STRATEGIES

We will focus next on how environmental factors can be more specifically examined to assess their influence on behavior. The practitioner engages in intensive analysis of the factors that support and maintain problematic behavior. Many resources are available which describe the principles of applied behavioral analysis. This discussion will touch briefly on only four important components of the process: the understanding of the SETTING in which the behavior takes place, the FREQUENCY or DURATION, and the ANTECEDENT as well as the CONSEQUENT influences.

S.36

Setting. The first functional assessment principle discussed by Cohen and Anthony (1984) focused on the need for environmental specificity. The first critical question to be answered is, "In what situations does problematic behavior occur?". In the home? ... At work? ... In public places? ... In isolation? One attempts to establish how generalized or situationally specific the problematic behavior may be. This indicates how complex and focused the resources associated with intervention must be. For example, will the strategies utilized in the Job Club be the same as those applied in the residential program?

Frequency. It is next important to ascertain the frequency or intensity of the problematic behaviors. Not only must we be interested in how frequently problematic behavior occurs, but also in the relative severity. A low frequency severe behavior problem such as self-abuse occurring once or twice a week would be considered more critical for intervention than a high frequency obsessive-compulsive behavior problem that is quite innocuous, such as hand wringing.

Antecedent influences. One next focuses on antecedent conditions. What led up to the behavior in question? Antecedent events are rich and complex in their presentations and cover a number of spheres beyond the "behavioral" one that is most commonly conceived. A few examples are seen in Table 5. S.37

Table 5

Antecedent Events that may lead to Problematic Behavior

EVENT CATEGORY	EXAMPLE
Cognitive	Impulsive cognitive set, failure to appreciate full ramifications of action
Affective	Feeling dysphoric on a particular day
Interpersonal	Low self-esteem with overreaction to ridicule
Situational	Repeat of same circumstances encountered last week
Imaginary	Fantasy of worst case scenario - "I'm sure I'll fail."
Biological	Lack of sleep the night before, and forgot morning medications

Any one or a combination of these factors could trigger problematic behavior. The practitioner's job is to delineate isolated (infrequent) antecedent events from those which are encountered more frequently and tend, therefore, to sustain the problematic behavior.

Consequence. The consequence of a behavior affects its frequency, duration and intensity. Consequences serve to strengthen, weaken, or extinguish a problematic behavior. The "art" in applied behavioral intervention centers on the ability to grasp the nuances of the reinforcement hierarchies that shape behavior. Simply defined, reinforcers are environmental consequences which increase the probability a preceding behavior will occur or be learned in the future. In populations of persons with chronic psychiatric disability, an important function in rehabilitation is one of propogating a set of new, socially appropriate reinforcers to help sustain desired behaviors.

BEHAVIORAL EXCESSES, DEFICITS, AND ASSETS

S.38

One can well imagine at this point that a comprehensive assessment of a person with a long term chronical mental illness could result in the identification of multiple problematic behaviors. The practitioner is faced with numerable issues which have the potential to positively or negatively impact behavior in a particular program. One means of dealing with this potential "information overload" is to reframe behaviors in the context of excesses, deficits, and assets. In this fashion, the most problematic negative behaviors are identified (the deficits and excesses), while at the same time the focus of the client is also directed toward his or her assets. These assets represent

"building blocks." By "keying" on assets, adaptive behavior can be strengthened and problematic behavior displaced.

Behavioral excesses represent maladaptive behaviors that occur at rates or intensities so high that they interfere with normal adaptive functioning. Handwashing, a routine activity, becomes pathogonomic in the patient with obsessive-compulsive disorder when it occurs 50 times a day. Behavioral deficits represent necessary behaviors that occur with insufficient frequency, inadequate intensity, or in an inappropriate form. The "negative symptoms" of clients having schizophrenia are representational of this class of deficits. Behavioral assets include the social competencies, coping efforts, skills, interests, and abilities of the client, as well as his or her available social supports.

Moving beyond the simple identification of "strengths and needs" one needs to translate outcome goals to specific behavioral categories that will become the object of treatment intervention. This is readily seen in the following example. A middle aged male with a chronic history of refractory schizophrenic symptomology is discharged from a state hospital to your care. He presents with very good social-conversational skills. His delusions, however, remain quite chronic. He becomes self-absorbed with their content, particularly when he is alone or idle. He spends greater than 70% of every idle hour engaged in "self-talk." Lower rates of reported delusional references are reported when he is engaged in social activities. When information is reported and structured in this fashion, it becomes readily apparent what strategies you might immediately consider regarding intervention.

We will address one further point in this regard-- the need to train ourselves to refocus our assessments on identification of assets. It becomes

increasingly easy to slip into a cognitive set in which we focus primarily on analysis of client deficits. We are repeatedly reminded to focus on assets from a number of quarters. You have noted that even in DSM-III-R diagnostic formulations there is an emphasis on assets or a documentation of "the highest level of adaptive functioning". In conducting functional assessments one should attempt to develop an "Inventory of Assets." We emphasize the need to go beyond the simple listing of strengths as might be ascertained from an adaptive behavior rating scale. The inventory should include an analysis of the supplemental information that can be derived from interview, collection of records, and review of history, all of which make this information more situationally relevent. The following questions can be used to organize this information:

1. What are the areas in which the client has consistently functioned best now and in the immediate past?
2. What does my client view as his or her most significant asset?
3. What is the extent of his or her available resources in terms of interpersonal and social supports?
4. What agencies and helping professionals are available to be mobilized in his or her behalf? With whom are there established favorable relationships?
5. What personal motivations and incentive to change have been identified?
6. What are the positive aspects of my therapeutic alliance with this client?

When we move beyond the simple listing of "assets" to considering their implications in terms of "systems related issues" that are pertinent to the

client's support, we have laid a foundation for the transfer of this information into viable recommendations for service or treatment.

THE NESTED SKILLS APPROACH TO ASSESSMENT AND TRAINING

We will offer one final strategy to be incorporated in the methodologies of functional assessment recommended as appropriate for use with this population. Critical in the rehabilitation of the individual with long term chronic disability is the question of whether or not the client can be trained and carry out routines of behavior. Our lives do not consist of carrying out discrete, isolated behaviors. Rather, our behavior reflects intricate routines and sub-routines organized in a complex interdependent fashion. Groups of actions are organized to meet the environmental demands with which we are confronted. S.39

Up to now we have only spoken of functional assessment and intervention strategies occurring in a unitary or discrete fashion. Are they present or absent? How frequently do they occur? A more critical question centers on the ability of the client to carry out complex multi-step operations and integrated actions. How effective is he or she in adapting behavior in the face of conflicting or changing environmental demands. How complex a routine is he or she capable of carrying out?

Let's consider an example taken from the assessment of self-care skills associated with early morning routines. Typically we would assess component skills associated with the discrete activities involved, i.e., toileting, washing, shaving, toothbrushing, grooming, dressing. When we think of our own behavior, we quickly realize how we rely upon "routines" in conducting such activities. It is frequently the case that we could assess our client and find

him or her fully competent when asked to perform appropriately each isolated activity. Missing in this limited analysis, however, is the evaluation of the degree to which the client can self-initiate and self-monitor these activities. Specifically, is he or she self-motivated to perform this sequence of activities daily? Are there breakdowns in the sequence such that day to day they are completed in "hit or miss" fashion? Are some behaviors initiated appropriately, but haphazardly carried out? Clients facing the consequences of long term chronic mental illness typically have not lost the basic skills in conducting such activities, but have developed deficiencies in the "executive functions" which relate to planning, organizing, or maintaining such activities. Although this is perhaps an overly simplistic example, one can extend the analogy to some of the complex behavioral expectancies we impose on our clients. We must be mindful of breaking our assessment and training strategies into formats that permit a determination of how well the client can proceed through multi-step and sequential operations. Critical in this regard is the question, "Can the client consistently maintain these sequences?". We will frequently find that we do not have to engage in skill acquisition training, as much as we have to refocus on developing strategies that will aid the client in the more effective use of the self-monitoring, judgement, and reasoning skills needed to maintain daily routines.

RESOURCE MANAGEMENT

Once the functional assessment has been conducted and goals identified, resources must be inventoried and organized before proceeding with the rehabilitation plan. The client and counselor must actively consider the required resources which will have to be brought to bear in program

implementation. This relates to multiple factors such as time, money, agencies, facilities, or transportation. There will need to be a delineation of who will assume the responsibility to carry out individual aspects of the plan. A comprehensive assessment of the client's capacity to carry out complex behaviors as highlighted above should aid greatly in determining the degree to which support will have to be extended in various areas. This support, in turn, will facilitate the client's maximum participation in the rehabilitation process.

SUMMARY

An overview of principles associated with functional assessment has been provided. An attempt was made to highlight a variety of methodologies available toward this end. Within this context, special considerations were advanced which related to the assessment needs of clients having chronic psychiatric disability. We return to the comments made at the beginning of this presentation. Functional assessment was conceived as an important tool to supplant limitations associated with more traditional testing for treatment planning. We would hope that the practitioner utilizing the functional assessment technologies described above not only incorporates them wisely, but also extends the general philosophy of assessment which has been advanced. In a truly comprehensive approach toward assessment, adoption of a functional approach toward testing provides a definition of the client's: 1) information processing style, 2) cognitive strengths and deficits, 3) problem solving skills, 4) coping resources, 5) personality style, as well as 6) strengths and weaknesses in environmentally specific skills that pertain to his or her residence, work, and social milieus.

S.40

Functional assessment represents not a mechanistic approach to problem identification via the pat administration of behavior rating scales, but rather it represents a philosophy which can be adapted toward more traditional forms of medical, psychological, and social casework assessment strategies as well. Indeed, this philosophy can be adapted to any evaluation which attempts to contribute to the understanding of how the quality of life and independence of a client with chronic mental illness can be furthered.

We will now conduct an exercise which helps illustrate a number of the points we made in this presentation.

PSYCHOSOCIAL SUMMARY

Client Name _____ Evaluator _____

ID Number _____ Agency _____

Date _____

Basic Environmental Supports

Does the client have an effective support system?

Family	____ Y	____ N
Peer	____ Y	____ N
Institutional	____ Y	____ N

Does the client maintain a stable residence? ____ Y ____ N

Is the client active with a MH provider? ____ Y ____ N

Specify corrective action if necessary:

_____

_____

_____

Physical Health

Are there significant physical health problems? ____ Y ____ N

Describe (i.e., well-controlled, may complicate programming):

_____

_____

_____

If indicated, is follow-up provided? ____ Y ____ N

Describe (i.e., where, by whom, how often):

_____

_____

_____

Psychiatric Status

Check for the presence of any major symptom cluster

If Present:	Acute	Chronic/Residual	In Remission
_____ Psychotic Experiences	_____	_____	_____
_____ Depression	_____	_____	_____
_____ Manic Symptoms	_____	_____	_____
_____ Anxiety or Fears	_____	_____	_____
_____ Obsessions or Compulsions	_____	_____	_____
_____ Organic Dysfunction	_____	_____	_____
_____ Drug Abuse	_____	_____	_____
_____ ETOH Abuse	_____	_____	_____
_____ Suicide Attempts	_____	_____	_____
_____ Other Symptoms	_____	_____	_____

Specify action necessary around any current symptoms manifestation:

_____

_____

_____

_____

Has the client demonstrated consistent medication compliance? _____ Y _____ N

For how long? _____

Intrapersonal Factors:

Can client readily discuss impact of his symptoms on behavior and lifestyle? _____ Y _____ N

If no, does he/she tend to:

_____ Deny

_____ Avoid

_____ Use Sick Role

Client's personal rehabilitation aims/personal incentives toward change:

Noteworthy disincentives toward maintenance of employment:

CRITICAL SKILLS CHECKLIST

Client name _____ Evaluator _____

ID Number _____ Agency _____

Date _____

INSTRUCTIONS: Circle the appropriate category indicating how well each of the following critical skills are performed according to the definition key below:

Very Poor (1) - skill performance is very poor or absent

Poor (2) - skill performance is poor or inconsistent at best

Adequate (3) - skill performance is adequate (meets current needs)

Good (4) - skill performance is good (effective, consistent/efficient)

Superior (5) - skill performance is highly satisfactory (particular strength)

No (N) - cannot be determined; skill performance in need of further evaluation

The Environmentally Specific Comments section is used to specify environmental and behavioral parameters in summarizing skill performance, i.e., quantity: frequency, duration, consistency, reliability; quality: thoroughness, accuracy, desirability, expediency, efficacy; and level of independence: level/frequency of supervision, prompting. Comments here should further elucidate client strengths which may be capitalized upon, as well as deficit areas which may be targeted for intervention.

Specify the environment for which this assessment was completed: _____

_____

A. LANGUAGE/COMMUNICATION

- engages in every day conversation 1 2 3 4 5 N
- understands verbal commands, directions 1 2 3 4 5 N
- responds to nonverbal contextual cues 1 2 3 4 5 N
- expresses needs & feelings 1 2 3 4 5 N

Environmentally Specific Comments:

B. MEMORY AND LEARNING

- recalls basic environmental information (names, address,telephone and Social Security number, simple directions) 1 2 3 4 5 N
- remembers appointment times and schedule of activities 1 2 3 4 5 N
- recalls long-term information (work or educational history) 1 2 3 4 5 N
- comprehends written materials 1 2 3 4 5 N
- learns from hands-on experience 1 2 3 4 5 N
- learns from verbal instructions 1 2 3 4 5 N

Environmentally Specific Comments:

C. ATTENTION/CONCENTRATION

- sustains attention to aurally presented information 1 2 3 4 5 N
- sustains attention to task task at hand 1 2 3 4 5 N

Environmentally Specific Comments:

D. PROBLEM SOLVING AND CONCEPTUALIZATION

- makes reasonable decisions 1 2 3 4 5 N
- formulates a plan 1 2 3 4 5 N
- carries out a plan 1 2 3 4 5 N
- generalizes a concept across settings 1 2 3 4 5 N
- responds to constructive criticism 1 2 3 4 5 N

Environmentally Specific Comments:

E. DAILY LIVING

- attends to personal hygiene (shower, shampoo, deodorant) 1 2 3 4 5 N
- uses a telephone 1 2 3 4 5 N
- engages in leisure time activities 1 2 3 4 5 N
- reads a newspaper 1 2 3 4 5 N
- budgets money 1 2 3 4 5 N
- plans a nutritionally balanced meal 1 2 3 4 5 N
- prepares meals adequately 1 2 3 4 5 N
- shops for personal items 1 2 3 4 5 N
- uses public transportation 1 2 3 4 5 N
- accesses necessary resources (Social Security, Medical care, etc.) 1 2 3 4 5 N

Environmentally Specific Comments:

F. SELF APPRAISAL AND JUDGMENT

- evaluates severity of external stressors 1 2 3 4 5 N
- copes with mild stress 1 2 3 4 5 N
- seeks support if unduly stressed 1 2 3 4 5 N
- verbalizes relevant and appropriate personal goals 1 2 3 4 5 N

Environmentally Specific Comments:

G. STAMINA AND TOLERANCE

- tolerates a 6-8 hour workday 1 2 3 4 5 N
- lifts objects 35-50 lbs 1 2 3 4 5 N
- traverses 100 yards without fatigue 1 2 3 4 5 N

Environmentally Specific Comments:

KEY:
1 = Very Poor
2 = Poor
3 = Adequate
4 = Good
5 = Superior
N = In need of further evaluation

APPENDIX

BIBLIOGRAPHY

1 Katz, S., Ford, A., Moskowitz, R., Jackson, B. & Jaffe, M. 1963. Studies of illness in the aged. The Index of ADl standardized measure of biological and psychosocial function. JAMA 185, 914-919.

2 Diller, L., Fordyce, W., Jacobs, D. & Brown, M. 1980. Self-administered frequency format of the Activity Pattern Indicators. New York: Rehabilitation Indicators Project, New York University Medical Center.

3 Granger, C. & Gresham, G. (Eds.) 1984. Functional assessment in rehabilitation medicine. Baltimore: Williams and Wilkins.

4 Torkelson, R., Jellinek, H., Malec, J. & Harvey, R. 1982. Medical/physical and psychological factors related to rehabiitation outcome and length of stay following craniocerebral trauma. Presented at meetings of American Congress of Rehabilitation Medicine, Houston, Texas.

5 Mahoney, F. & Barthel, D. 1965. Functional evaluation: Barthel Index. Maryland State Med. J. 14, 61-65.

6 Ben-Yishay, Y. & Diller, L. 1983. Cognitive deficits. In M. Rosenthal, E. Griffith, N. Bond & J. Miller (Eds.), Rehabilitation of the head injured adult. Philadelphia: F.A. Davis Company.

7 Lynch, W. & Mauss, N. 1981. Brain injury rehabilitation: standard problem lists. Arch. Phys. Med. Rehabl. 62 223-227.

8 Meeder, D. 1982. Cognitive perceptual motor evaluation research findings for adult head injuries. In L. Trexler (Ed.), Cognitive rehabilitation. New York: Plenum Press.

9 Kulkarni, M. & Blom, G. 1984. Coping with disability inventory -- a tool for the evaluation of coping behaviors in disabled persons. Presented at meetings of American Congress of Rehabilitation Medicine, Boston.

10 Rappaport, M., Hall, K., Hopkins, K., Belleza, T. & Cope, D. 1982. Disability Rating Scale for severe head trauma: coma to community. Arch. Phys. Med. Rehabil. 63, 118-123.

11 Crewe, N. & Athelstan, G. 1981. Functional assessment in vocational rehabilitation: a systematic approach to diagnosis and goal setting. Arch. Phys. Med. Rehabil. 62, 229-305.

12 Halstead, L. & Alexander, J. 1979. Functional outcome assessment: a practical new approach to follow-up. Presented at meetings of American Congress of Rehabilitation Medicine, Honolulu.

13 Goodwin, D. 1983. Cognitive and physical recovery trends in severe closed head injury. Disserta. Abstr. Int. 43, No. 9, p. 3066-B. Ann Arbor, MI: University Microfilms International.

14 Bolton, B. 1974. Introduction to rehabilitation research. Springfield, IL: Charles C. Thomas.

15 DeJong, G. & Hughes, J. 1982. Independent living: methodology for measuring long-term outcomes. Arch. Phys. Med. Rehabil. 63, 68-73.

16 Aitken, M. 1982. Self-concept and functional independence in the hospitalized elderly. Am. J. Occup. Ther. 36, 243-250.

17 Schoening, H., Anderegg, L., Gergstrom, D., Fonda, J., Stein, N. ;& Ulrich, P. 1965.

18 Keith, R. 1984. Functional assessment measures in medical rehabilitation: current status. Arch. Phys. Med. Rehabil. 65, 74-78.

19 Chambers, L., Sackett, D., Goldsmith, C., Macpherson, A. & McAuley, R. 1976. Development and application of Index of Social Function. Health Seriv. Res. 11, 430-441.

20 Holt, N., Carlson, C., King, R., Johnson, J., Keenan, M., Kubalanza-Sipp, D., Boynik, M. & Harasymiw, S. 1982. Prediction of post discharge risk in spinal cord injured persons. Presented at meetings of American Congress of Rehabilitation Medicine, Houston, Texas.

21 Harvey, R. & Jellinek, H. 1981. Functional performance assessments: a program approach. Arch. Phys. Med. Rehabil. 62, 456-461.

22 Moskowitz, E. & McCann, C. 1957. Classification of disability in chronically ill and aging. J. Chronic Dis. 5, 342-346.

23 Labi, M., Dittman, S., Hicks, J., Joyce, S., Phillips, M. & Gresham, G. 1979. Quadriplegia Index of Function: one year follow-up report. Presented at meetings of American Congres of Rehabilitation Medicine, Honolulu.

24 Reagles, K., Wright, G. & Butler, A. 1970. A Scale of Rehabilitation Gain for clients of an expanded vocational rehabilitation program. Wisconsin Studies in Vocational Rehabilitation. Monogr XIII, Series 2. Madison: Wisconsin Regional Rehabilitation Research Institute.

25 Walls, R. & Tseng, M. 1976. Measurement of client outcomes in rehabilitation. In B. Bolton (Ed.), Handbook of measurement and evaluation in rehabilitation. Baltimore: University Park Press.

26 Glass, D. & Yuck Sinn Loo, S. 1979. Early prognosis factors of the disability outcome SCORE. Presented at meetings of the American Congress of Rehabilitation Medicine, Honolulu.

27 Mackworth, N., Mackworth, J. & Cope, N. 1982. Cognitive-visual assessment of head injury recovery to predict social outcome by measuring verbal speeds and sequencing skills. In Head injury project final report. San Jose, CA: Santa Clara Valley Medical Center.

28 Kaufert, J. 1983. Functional ability indices: measurement problems in assessing their validity. Arch. Phys. Med. Rehabil. 64, 260-267.

29 Vaugh... T. 1967. Special education: outcomes charts. Greely, CO: Colorado State College.

References

Clarke, A.M. & Clarke, A.D.B. (1974). Mental Deficiency (3rd Edition). New York: The Free Press.

Cohen, B.F. & Anthony, W.A. (1984). Functional assessment in psychiatric rehabilitation. In A.S. Halpern & M.J. Fuhrer (Eds.), Functional assessment in rehabilitation (pp. 79-100). Baltimore: Paul H. Brookes.

FUNCTIONAL ASSESSMENT

Gregory T. Slomka, Ph.D.

Slide 1.

ASSESSMENT (Clarke & Clarke, 1976)

1) Describes an individual at a particular point in time in terms of intellectual, social, emotional, educational, and allied variables with reference to a normative or contrast population.
2) Predicts performance of an individual at a future point in time.
3) Provides a profile of assets and deficits in order to determine the starting point for further intervention.
4) Provides an objective means to monitor progress over time.

Slide 2.

FUNCTIONAL ASSESSMENT

A MEASURE OF WHAT A PERSON CAN OR CANNOT DO (STRENGTHS/WEAKNESSES) IN PARTICULAR SITUATIONS AND IN LIGHT OF PARTICULAR GOALS AND OBJECTIVES

Slide 3.

RATIONALE FOR FUNCTIONAL ASSESSMENT OF CMI INDIVIDUALS

1) PROVIDES INFORMATION ON SPECIFIC ABILITIES AND FUNCTIONAL LIMITATIONS.
2) IDENTIFIES THE PRESENCE OF SOCIAL/INTERPERSONAL DEFICITS.
3) IDENTIFIES LEARNING STYLES AND EFFECTIVE COMMUNICATION TECHNIQUES.
4) IDENTIFIES REMEDIATION AND COMPENSATION CONSIDERATIONS.
5) PROVIDES INFORMATION REQUIRED FOR PLANNING AND ACCOMMODATION TO CHANGE.
6) IDENTIFIES EDUCATIONAL AND TRAINING NEEDS.
7) IDENTIFIES JOB PLACEMENT NEEDS.
8) IDENTIFIES COMMUNITY SUPPORT NEEDS.

Slide 4.

SOURCES OF FUNCTIONAL ASSESSMENT DATA

- DIAGNOSTIC INFORMATION
- TEST RESULTS
- QUESTIONNAIRES AND SURVEYS
- DIRECT OBSERVATIONAL TECHNIQUES
- CLIENT SELF MONITORING
- CLIENT INTERVIEW
- SIGNIFICANT OTHERS
- HISTORICAL INFORMATION
- PRACTITIONER COLLABORATION

Slide 5.

METHODS OF FUNCTIONAL ASSESSMENT:

- BEHAVIORAL INTERVIEWING
- DIRECT OBSERVATION
- SELF-OBSERVATION
- CHECKLISTS, QUESTIONNAIRES, AND RATING SCALES

Slide 6.

FUNCTIONAL ASSESSMENT INSTRUMENTS

FUNCTIONAL ASSESSMENT INVENTORY (FAI)

PERSONAL CAPACITIES QUESTIONNAIRE (PCQ)

PATIENT'S ASSESSMENT OF OWN FUNCTIONING INVENTORY (PAOFI)

REHABILITATION INDICATORS (RIs)

Slide 7.

SCALES IN THE FUNCTIONAL ASSESSMENT INVENTORY (FAI) GROUPED ACCORDING TO APPARENT CONTENT

Motor
- Upper extremity functioning
- Hand functioning
- Coordination
- Ambulation or mobility
- Motor speed
- Capacity for exertion
- Endurance
- Speech

Social and biographical
- Effective interaction with people
- Personal attractiveness
- Skills
- Work history
- Absence from work due to treatment or medical problems
- Stability of condition
- Social support system

Psychological and intellectual
- Learning ability
- Judgment
- Memory
- Literacy
- Language functioning
- Perceptual organization
- Persistence
- Work habits
- Consistency of behavior with rehabilitation goals
- Accurate perception of disability

Sensory
- Vision
- Hearing

Environmental
- Access to job opportunities
- Economic disincentives
- Acceptability to employers

Slide 8.

SAMPLE RATING SCALES OF THE FAI

Functional Limitations Scale No. 10: Endurance
- 0 -- No significant impairment
- 1 -- Can work full day with rest periods arranged
- 2 -- Can work only about half-time
- 3 -- Unable to work for more than 1 or 2 hours a day

Functional Limitations Scale No. 13: Judgment
- 0 -- No significant impairment
- 1 -- Sometimes makes unsound decisions: doesn't take time to consider alternative or consequences of behavior
- 2 -- Frequently makes rash or unwise decisions; often displays inappropriate behavior or choices
- 3 -- Could be dangerous to self or others as a result of foolish or impulsive behavior

Functional Limitations Scale No. 27: Work History

0 -- No significant impairment

1 -- Has little or no work experience due to youth or other reasons acceptable to most employers

2 -- Work history includes such negative aspects as frequent tardiness or frequent job changes with periods of unemployment

3 -- May have periods of unemployment as great as 5 years; references when available are poor

Strength Items

- Has an unusually attractive physical appearance
- Is extremely bright, or has an exceptional verbal fluency
- Is extremely motivated to succeed vocationally

Slide 9.

FUNCTIONAL ASSESSMENT PRINCIPLES
(COHEN & ANTHONY, 1984)

FUNCTIONAL ASSESSMENT NEEDS TO RELATE TO AN OVERALL REHABILITATION GOAL THAT IS ENVIRONMENTALLY SPECIFIC.

THE LANGUAGE OF FUNCTIONAL ASSESSMENT MUST BE BEHAVIORALLY DEFINED.

FUNCTIONAL ASSESSMENT IS ALWAYS INDIVIDUALIZED.

FUNCTIONAL ASSESSMENT MUST BE COMPREHENSIVE.

FUNCTIONAL ASSESSMENT REQUIRES ACTIVE CLIENT INVOLVEMENT.

FUNCTIONAL ASSESSMENT SHOULD FOCUS ON STRENGTHS AS WELL AS DEFICITS.

FUNCTIONAL ASSESSMENT REQUIRES THAT THE CLIENT AND THE EVALUATOR UNDERSTAND BOTH PRESENT AND ANTICIPATED NEEDS.

Slide 10.

FUNCTIONAL ASSESSMENT MUST RELATE TO AN OVERALL

REHABILITATION GOAL THAT IS ENVIRONMENTALLY SPECIFIC.

Slide 11.

AREAS IN WHICH ADAPTIVE FUNCTIONING MIGHT BE ASSESSED

SELF-CARE

HOUSEKEEPING

LEISURE

PERSONAL BUSINESS AND FINANCE

CONSUMER ACTIVITIES

SCHOOL

WORK

SPECIAL EVENTS

Slide 12.

FUNCTIONAL ASSESSMENT REQUIRES THAT SKILLS AND DEFICITS BE BEHAVIORALLY DEFINED.

Slide 13.

WORKER ROLE KNOWLEDGE AND SKILLS

- APPROPRIATE VOCATIONAL GOAL
- ADEQUATE KNOWLEDGE OF VOCATIONAL OPTIONS
- APPLICATION SKILLS
- INTERVIEW SKILLS
- CLIENT/CO-WORKER INTERACTIONAL SKILLS
- CLIENT/SUPERVISOR INTERACTIONAL SKILLS
- ADEQUATE KNOWLEDGE OF WORKER ROLE REQUIREMENTS

Slide 14.

FUNCTIONAL COMMUNITY SKILLS

- TRANSPORTATION SKILLS
- FUNCTIONAL ACADEMIC SKILLS
- SELF-CARE SKILLS (HYGIENE, NUTRITION)
- USE OF MONEY
- MANAGEMENT OF PERSONAL AFFAIRS
- MEDICAL CARE

Slide 15.

SOCIAL AND COMMUNICATION SKILLS

- FACE TO FACE COMMUNICATION
- SOCIAL INVOLVEMENT
- LEISURE AND RECREATION
- TELEPHONE SKILLS
- ABILITY TO MEET PEOPLE
- ABILITY TO "GET ALONG" WITH OTHERS

Slide 16.

EFFECTIVE FUNCTIONAL ASSESSMENT IS ALWAYS INDIVIDUALIZED.

Slide 17.

FUNCTIONAL ASSESSMENT MUST BE COMPREHENSIVE.

Slide 18.

VOCATIONAL FUNCTIONING AND POTENTIAL

THE DEGREE TO WHICH A CLIENT DEMONSTRATES CAPACITY TO APPRAISE REALISTICALLY HIS/HER OWN VOCATIONAL POTENTIAL AND TO EXHIBIT PHYSICAL AND EMOTIONAL ENDURANCE NECESSARY TO ACHIEVE VOCATIONAL OBJECTIVES

Slide 19.

ECONOMIC INDEPENDENCE

THE DEGREE TO WHICH THE CLIENT CAN FUNCTION INDEPENDENTLY IN SOCIETY WITHOUT RELIANCE ON PUBLIC SUPPORT FOR INCOME AND SOCIAL SERVICE

Slide 20.

PHYSICAL FUNCTIONING

THE DEGREE TO WHICH THE CLIENT DEMONSTRATES THE CAPACITY FOR REDUCTION OF SYMPTOMS, IMPROVED PHYSICAL TOLERANCE, DEVELOPMENT OF PRACTICAL COMPENSATORY MECHANISMS, AND INCREASED ENDURANCE

Slide 21.

PSYCHOSOCIAL FUNCTIONING

THE DEGREE TO WHICH A CLIENT DEMONSTRATES SOCIAL AND PSYCHOLOGICAL ADAPTABILITY WHICH SERVE TO ENHANCE FEELINGS OF SECURITY, ADEQUACY, FUNCTIONAL CAPABILITY, EMOTIONAL STABILITY, AND SOCIAL INTERACTION

Slide 22.

FUNCTIONAL ASSESSMENT REQUIRES ACTIVE CLIENT INVOLVEMENT.

Slide 23.

FUNCTIONAL ASSESSMENT SHOULD INCLUDE A MEANS FOR MEASUREMENT OF BEHAVIORAL SKILLS STRENGTHS AS WELL AS DEFICITS.

Slide 24.

FUNCTIONAL DEFICITS FREQUENTLY NOTED IN THE CMI

- IMPAIRMENT OF ABSTRACT ATTITUDE
- CONCRETE THINKING
- INABILITY TO MAKE GENERALIZATIONS
- MISINTERPRETATION OF SPOKEN, WRITTEN LANGUAGE
- FAILURE TO ATTEND
- LACK OF MOTIVATION
- FAILURE TO PERSIST IN TASKS
- LACK OF EAGERNESS AT WORK
- INABILITY TO GET ALONG WITH OTHERS
- LACK OF INITIATIVE
- PSYCHOMOTOR ABNORMALITIES
- DISTURBANCE OF MEMORY AND LEARNING
- SLOW TO PROCESS INFORMATION
- DIFFICULTY IN CATEGORIZING AND ORGANIZING INPUT

Slide 25.

FUNCTIONAL ASSESSMENT REQUIRES AN UNDERSTANDING OF BOTH PRESENT AND NEEDED LEVEL OF FUNCTIONING OF THE CLIENT.

Slide 26.

FUNCTIONAL ASSESSMENT IS A MEANS TO DESCRIBE ABILITIES.

Slide 27.

THE GOAL OF FUNCTIONAL ASSESSMENT

TO DEVELOP A PERFORMANCE-ORIENTED DATABASE OR PROFILE

Slide 28.

FROM THIS PROFILE:

PROBLEMS OR NEEDS ARE IDENTIFIED

INTERVENTIONS ARE PLANNED

LONG RANGE GOALS ARE DEVELOPED

Slide 29.

FUNCTIONAL ASSESSMENT PROVIDES CORE INFORMATION FOR "CASE MANAGEMENT".

Slide 30.

FUNCTIONAL ASSESSMENTS REQUIRE SKILLS BE BEHAVIORALLY DEFINED.

Slide 31.

A SKILL IS A SET OF BEHAVIORS THAT IS:

OBSERVABLE

TEACHABLE

MEASUREABLE

Slide 32.

RULE OF THE FIVE "Ws"

WHO IS PERFORMING

WHAT BEHAVIORS ARE THE FOCUS

AND THE CIRCUMSTANCES (WHERE, WHEN, WITH WHOM)

Slide 33.

FACTORS OF PERSONS HAVING CMI WHICH INFLUENCE VOCATIONAL OUTCOME

1. ADJUSTMENT TO DISABILITY
2. COGNITIVE/INTELLECTUAL ABILITIES
3. DECISION MAKING ABILITIES
4. DEPENDENCY ON OTHERS FOR FINANCIAL SUPPORT
5. DISINCENTIVES (E.G., SEVERELY LIMITING MEDICAL CONDITIONS)
6. PREMORBID EDUCATIONAL LEVEL
7. EMOTIONAL STATUS
8. INDEPENDENCE IN LIVING, MOBILITY, AND JOB PERFORMANCE

Slide 34.

9. MARITAL STATUS AND NUMBER OF DEPENDENTS
10. MOTIVATION AND EGO STRENGTH
11. PERCENT OF TIME ABLE TO WORK
12. PHYSICAL STATUS
13. PRODUCTIVITY (INCLUDING CREATIVE AND COMMUNITY ACTIVITIES)
14. SOCIAL FUCNTIONING
15. DEGREE OF TRAINING REQUIRED FOR JOB COMPETENCE FOLLOWING ILLNESS/INJURY

Slide 35.

SUB-SETS OF SYMPTOM-RELATED PROBLEMS:

1. SENSORY-PERCEPTUAL DISTURBANCE
2. COGNITIVE DISTURBANCE
3. LANGUAGE RELATED DISTURBANCES
4. PRAXIC (MOTOR) DISTURBANCE
5. DISRUPTED EXECUTIVE FUNCTIONS

Slide 36.

IMPORTANT COMPONENTS OF THE PROCESS OF

APPLIED BEHAVIORAL ANALYSIS:

SETTING

FREQUENCY/DURATION

ANTECEDENT INFLUENCES

CONSEQUENCES

Slide 37.

ANTECEDENT EVENTS THAT MAY LEAD TO PROBLEMATIC BEHAVIOR

EVENT CATEGORY	EXAMPLE
Cognitive	Impulsive cognitive set, failure to appreciate full ramifications of action
Affective	Feeling dysphoric on a particular day
Interpersonal	Low self-esteem with overreaction to ridicule
Situational	Repeat of same circumstances encountered last week
Imaginary	Fantasy of worst case scenario - "I'm sure I'll fail."
Biological	Lack of sleep the night before, and forgot morning medications

Slide 38.

EXCESSES

DEFICITS

ASSETS

Slide 39.

NESTED SKILLS APPROACH

Slide 40.

A FUNCTIONAL APPROACH TOWARD PSYCHOLOGICAL TESTING PROVIDES A DEFINITION OF:

1. INFORMATION PROCESSING STYLE
2. COGNITIVE STRENGTHS AND DEFICITS
3. PROBLEM SOLVING SKILLS
4. COPING RESOURCES
5. PERSONALITY STYLE

PSYCHOSOCIAL SUMMARY

Client Name _____ Evaluator _____

ID Number _____ Agency _____

Date _____

Basic Environmental Supports

Does the client have an effective support system?

Family	____ Y	____ N
Peer	____ Y	____ N
Institutional	____ Y	____ N

Does the client maintain a stable residence? ____ Y ____ N

Is the client active with a MH provider? ____ Y ____ N

Specify corrective action if necessary:

_____

_____

_____

Physical Health

Are there significant physical health problems? ____ Y ____ N

Describe (i.e., well-controlled, may complicate programming):

_____

_____

_____

If indicated, is follow-up provided? ____ Y ____ N

Describe (i.e., where, by whom, how often):

_____

_____

_____

U.S. Department of Education
Office of Educational Research and Improvement (OERI)
Educational Resources Information Center (ERIC)

REPRODUCTION RELEASE

(Specific Document)

I. DOCUMENT IDENTIFICATION:

EC305483

Title: Clinical Internship Training Program in Psychiatric-Vocational Rehabilitation

Author(s): Michelle O. Geckle, M.Ed., CRC & Lynda J. Katz, Ph.D.

Corporate Source: University of Pittsburgh
School of Health & Rehabilitation Sciences

Publication Date: March, 1997

II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, *Resources in Education* (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic/optical media, and sold through the ERIC Document Reproduction Service (EDRS) or other ERIC vendors. Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following two options and sign at the bottom of the page.

☒ Check here
For Level 1 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical) *and* paper copy.

The sample sticker shown below will be affixed to all **Level 1** documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Level 1

The sample sticker shown below will be affixed to all **Level 2** documents

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN OTHER THAN PAPER COPY HAS BEEN GRANTED BY

Sample

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

Level 2

☐ Check here
For Level 2 Release:
Permitting reproduction in microfiche (4" x 6" film) or other ERIC archival media (e.g., electronic or optical), but *not* in paper copy.

Documents will be processed as indicated provided reproduction quality permits. If permission to reproduce is granted, but neither box is checked, documents will be processed at **Level 1**.

"I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic/optical media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries."

Sign here→ please

Signature: Michelle O. Geckle	Printed Name/Position/Title: Michelle O. Geckle, Project Director
Organization/Address: Univ. of Pittsburgh, Rehab. Sci. & Tech. Forbes Tower, Suite 5044 Pittsburgh, PA 15260	Telephone: 412-344-6119 / FAX:
	E-Mail Address: / Date: 3-8-97